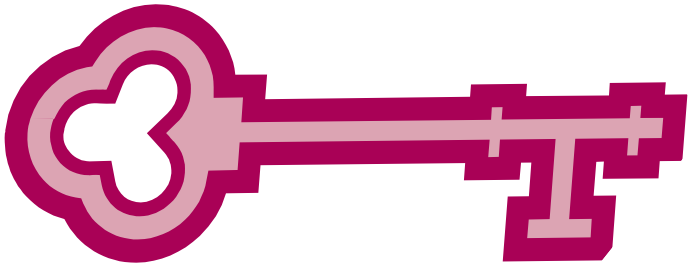
Benefit Choice Options

The Key to Understanding Your Benefits



Teachers' Retirement Insurance Program

Department of Central Management Services
Bureau of Benefits

Effective July 1, 2003 - June 30, 2004

Rod R. Blagojevich, Governor
Michael M. Rumman, Director

Important Changes For Fiscal Year 2004

The information below presents significant changes to the Teachers' Retirement benefit plans. Please carefully review all the information in this Benefit Choice Options booklet. **This annual Benefit Choice Options Booklet contains updates to the Teachers' Retirement Insurance Program Benefits Handbook.** Participants should review this publication each year to be aware of changes in the benefits available. Benefit Choice is May 1-31, 2003. All selections made during Benefit Choice will be effective July 1, 2003.

Changes that Impact All Participants

Life Changing Events - If you have a life changing event such as marriage, divorce, etc. , contact Teachers' Retirement System (TRS) to understand how your coverage may be impacted.

Health Insurance Portability and Accountability Act (HIPAA) - Title II of the federally enacted Health Insurance Portability and Accountability Act of 1996, commonly referred to as HIPAA, was designed to protect the confidentiality and security of health information and to improve efficiency in healthcare delivery. HIPAA standards protect the confidentiality of medical records and other personal health information, limit the use and release of private health information, and restrict disclosure of health information to the minimum necessary.

The Department of Central Management Services, Bureau of Benefits contracts with Business Associates (health plan administrators, Health Maintenance Organizations and other carriers) to provide services including, but not limited to, claims processing, utilization review, behavorial health services and prescription drug benefits.

If you have insured health coverage such as an HMO, you will receive a Notice of Privacy Practices from the respective plan administrator. If you are a plan participant in the TCHP, refer to page 24 for the Notice of Privacy Practices.

Changes specific to Managed Care Plans (HMO/OAP)

Plans no longer available - Humana HMO is no longer available. If you are enrolled in this plan, you will need to enroll in another managed care plan or in the Teachers' Choice Health Plan(TCHP). **If you do not make another plan selection before May 31, 2003, you will automatically be enrolled in TCHP effective July 1, 2003.** Information on the managed care plans will be mailed to your home. For details on plans in your area, see pages 12 -13.

Changes specific to the Teachers' Choice Health Plan (TCHP)

The TCHP Hospital Preferred Provider Organizations - will include 228 hospitals statewide including 3 additions and 6 deletions of providers. Refer to pages 20-23 for a complete listing.

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Participant Responsibilities

It is each Participant's responsibility to know the benefits. Read the information on the plan in which you are currently enrolled or in which you are considering enrolling.

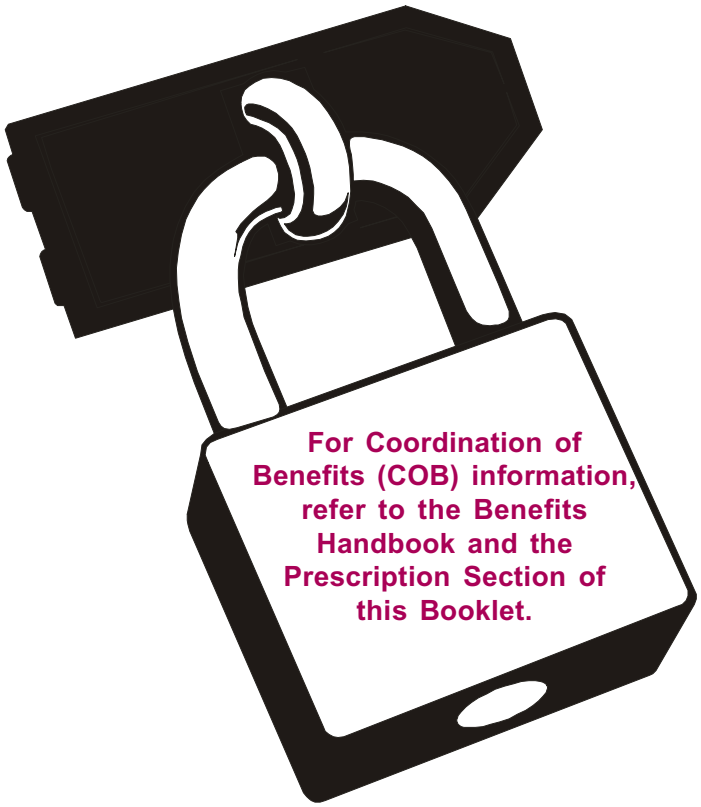
If you are unsure if an event occurs that the Teachers' Retirement System needs to know about, it is in your best interest to contact them for assistance. **Corrections to eligibility that result in a premium change will only be processed up to six months retroactively. There are no exceptions to this policy.**

Notify Teachers' Retirement System immediately when the following life changing events occur:

- You and/or your dependents have a change of address.
- You experience life changing events that may impact eligibility for you or your dependent(s) such as:
  - birth/adoption of a child,
  - marriage, divorce,
  - death of a covered dependent.
- You have other group insurance coverage, or gain other coverage during the plan year. Provide your Coordination of Benefit (COB) information to Teachers' Retirement System as soon as possible.

To ensure that all information is up-to-date, Participants should periodically review the following:

- Annual Benefit Choice Booklet which details changes affecting all benefit programs each plan year.
- Health and dental information from plans you are currently enrolled in or are considering enrolling in.
- Prescription formulary list. **Remember:** Formularies are subject to change during the plan year without notice.
- Your annuity deductions for health premiums are accurate, based on the coverage you have enrolled in for the plan year.



Benefit Choice Period is May 1-31, 2003

Benefit Choice Period is the time of year to review and/or make changes to your health plan. Benefit Choice is the **only** time, other than a qualifying change in status, that Participants can change plans (see Benefits Handbook). Benefit Choice is also the only time when those who have never been enrolled in a plan offered by TRIP may initially enroll in one of its health plans.

Benefit Choice runs from **May 1 through May 31, 2003.** The plan selections elected during this period will be in force for the plan year July 1, 2003 through June 30, 2004.

All Benefit Choice changes can be processed through TRS. Participants who do not anticipate making a health plan change should carefully review plan coverages and benefits for possible changes. **Remember: There can be changes in your coverage even if you do not change plans. It is each Participant's responsibility to review this Benefit Choice Options Booklet in its entirety.**

Whether to consider a change in your benefit plan, or to simply compare your current plan to another, review the features below. They will help you determine the best healthcare choices for you and your family.

Plans differ with respect to:

- Services covered
- Deductibles, copayment levels and out-of-pocket maximums
- Premium costs and possible geographic limitations
- Healthcare provider selection process
- Prescription drug coverage

The Teachers' Choice Health Plan (TCHP) is available regardless of your place of residence. Managed care plans have geographic and provider limitations. Participants interested in a managed care plan should carefully review each plan's benefits, the service area map and county list on pages 12 and 13 and the provider directories available from each plan. Specific questions regarding coverage should be directed to each respective plan administrator.

- **Managed Care Plans**
  HMO – Health Maintenance Organization
  OAP – Open Access Plan
- **Teachers' Choice Health Plan**
  TCHP – a medical indemnity plan

For information specific to participating managed care plans, contact the individual plans listed on page 28. For detailed information on the TCHP, refer to your Benefits Handbook. **It is your responsibility to know your benefits.** Read all information on the plan in which you are currently enrolled or in which you are considering enrolling.

Frequently Asked Questions (FAQs) about Benefits

1) Will the deductibles I have paid under my current healthcare plan transfer to the plan I select if I enroll in TRIP?

No, deductibles do not transfer. The TRIP Plan Year begins July 1 and so do all deductibles and out-of-pocket maximums, where applicable.

2) Since the Program is co-administered by TRS and CMS, who do I call with questions?

Contact TRS regarding enrollment, eligibility or to change your address. If TRS does not have your current address on file, you could miss important benefit information. Contact CMS for general information on coverage and benefits. For specific information on managed care plans, contact the respective plan, see page 28.

3) Do I get a new medical and prescription drug identification card every plan year?

Normally, the only times you will receive an identification card are when you first enroll in the plan, if you change plans, if the plan administrator changes or if you request new cards. If you lose your identification card, you may request a replacement card from your plan administrator listed on page 28.

4) I know managed care plans have geographic limitations. What if I move?

If your current plan is available at your new location, you will remain under that plan unless your PCP is no longer available there. If your PCP is not available, you will need to select a new PCP or you may change plans. If you move to a county where your current plan is not offered, you will have to choose a new plan. If you move out-of-state or out of the country, you will most likely have to enroll in TCHP. Contact the plan administrator for specifics and, as always, notify TRS of your new address.

5) If I am seeing a specialist or a woman's health care provider in my managed care plan's network and that professional leaves the network, can I change plans?

No. You will have to wait until the next Benefit Choice Period. The only time you may change plans is if your PCP leaves the network .

6) I am on Medicare and enrolled in TCHP. Do I have to use the TCHP Preferred Provider Organization networks for hospitals and physicians?

It is recommended that you use a PPO in case you have exhausted your Medicare benefits. Remember to call the Notification Administrator for all hospital/extended care facility admissions when your Medicare benefits exhaust or you will be subject to a $1,000 penalty for failure to notify.

7) I (or my dependent) have just become eligible for Medicare due to a medical condition (Medicare Disability or Medicare ESRD), but I am not yet 65 or retired. What should I do and how will this affect my coverage?

First, send a copy of your Medicare card to Teachers' Retirement System indicating whether you are receiving Medicare Disability or Medicare ESRD. Depending on the type of Medicare you are eligible for and the length of time you have been entitled to it, your Teachers' Retirement Insurance Program coverage may or may not be your primary payer. If you have questions about the coordination of benefits process with Medicare, call the Group Insurance Division, Member Services Section at (217) 558-4486.

8) I am Medicare primary and enrolled in TCHP. Do the annual plan and additional deductibles apply to me?

The only time the deductibles would apply is if the services you received are not covered by Medicare.

9) What if I want to terminate either my or my enrolled dependents' coverage under TRIP?

Notify TRS in writing of your decision to terminate coverage. Cancellation will be effective the first of the month following receipt of the request. **You can only re-enroll yourself or your dependent upon turning 65 or if your coverage is terminated by your existing plan.**

Monthly Premium Information

Your monthly premium is based upon the type of coverage you select and your permanent residence on file with TRS. This is why it is extremely important that you notify TRS of any eligibility and/or address changes as soon as possible. **Corrections to eligibility that result in a premium change will only be processed up to six months retroactively. There are no exceptions to this policy.**

Type of Plan	Not Medicare Primary Under Age 23	Not Medicare Primary Age 23-64	Not Medicare Primary Age 65 & Above	Medicare Primary All Ages
Benefit Recipient Enrolled in any TRIP Managed Care Plan	$54.49	$151.51	$203.04	$62.04
Benefit Recipient* Enrolled in TCHP Indemnity Plan when managed care is available in their county of residence	$108.99	$303.01	$406.08	$124.08
Benefit Recipient** Enrolled in TCHP Indemnity Plan when managed care plan is not available in their county of residence	$54.49	$151.51	$203.04	$62.04
Dependents*** Enrolled in any plan	$217.97	$606.02	$812.17	$248.17

* A benefit recipient who elects to enroll in the TCHP indemnity plan when a managed care plan is available in their county of residence will receive a reduced subsidy. The recipient's premium payment will be 50% of the rate. For example, using the above chart, if the recipient is Medicare primary, the premium would be $124.08.

** When managed care is not available in the benefit recipient's county of residence, the recipient may enroll in the TCHP indemnity plan without a reduction in subsidy. The recipient's premium payment will be 25% of the rate. For example, using the above chart, if the recipient is Medicare primary, the premium would be $62.04.

*** There is no subsidy for enrolled dependents. The dependent premium payment is 100% of the rate. For example, using the above chart, if the dependent is Medicare primary, the premium would be $248.17.

Managed Care Plans

There are 7 managed care plans from which to choose. Plans include Health Maintenance Organizations (HMOs) and an Open Access Plan (OAP). All offer comprehensive benefit coverage.

There are distinct advantages to selecting a managed care health plan – namely, lower out-of-pocket costs and virtually no paperwork. Like any health plan option, managed care has its limitations including geographic availability and limited provider networks. Members considering managed care are urged to explore and research the various plans available to them.

Health Maintenance Organizations (HMOs)

HMOs operate on an "in-network" structure. Members select a Primary Care Physician (PCP) from the HMO's network of participating providers. In conjunction with the health plan, the PCP directs **all** healthcare services for the member, including visits to specialists and hospitalizations. When care is coordinated through the PCP, the member pays only a predetermined copayment. There are no annual plan deductibles for HMO plans. The minimum levels of coverage HMO plans are required to provide are described on page 9.

Open Access Plan (OAP)

The unique feature of the OAP is that there are three benefit levels as shown in the table on page 10. The program offers two managed care networks, a Tier I network and a Tier II network. In addition, Tier III benefits (out-of-network) are available, so you can have great flexibility in selecting care providers. The important thing to remember is the level of benefits you receive is determined by the selection of care providers.

The benefit level for hospitals, physicians and other services will be highest if you select a Tier I provider - often a 100% benefit after a copayment. The Tier II network is generally a 90% benefit. The Tier III benefits (out-of-network) is generally 80% of Usual &Customary (U&C). See the table on page 10 for more details. The plan provider directory contains separate listings of providers in the Tier I and Tier II networks so that you will know in advance the level of benefits you will receive. Another advantage of selecting the network providers is that they have met strict accreditation standards.

It is important to know that you can mix and match providers. For example, you can utilize a Tier II physician and receive care in a Tier I hospital. In this example, your physician claim would be payable under Tier II at a 90% benefit and the hospital would be paid at the Tier I 100% benefit.

In considering the OAP, compare all benefits to other options. There are important similarities and differences in benefits for prescription drug coverages and mental health/substance abuse services, as well as hospital, physician and other services.

HMO Benefits

The benefits described below represent the minimum level of coverage the HMO is required to provide. Benefits are subject to the limitations outlined in the plan's Certificate of Coverage. It is your responsibility to know and follow the specific requirements of the HMO plan you select.

Plan Design	
Plan year maximum benefit	Unlimited
Lifetime maximum benefit	Unlimited
Hospital Services	
Inpatient hospitalization	100% after $150 copayment per admission
Alcohol/substance abuse* *(maximum number of days determined by the plan)*	100% after $150 copayment per admission
Psychiatric admission* *(maximum number of days determined by the plan)*	100% after $150 copayment per admission
Outpatient surgery	100%
Diagnostic lab & X-ray	100%
Emergency room hospital services	100% after $100 or 50% copayment, whichever is less
Professional and Other Services	
Physician visits *(including physical exams & immunizations)*	100%, $10 copayment may apply
Well Baby Care	100%
Psychiatric care* *(maximum number of days determined by the plan)*	100% after $20 or 20% copayment per visit
Alcohol and substance abuse care* *(maximum number of days determined by the plan)*	100% after $20 or 20% copayment per visit
Prescription drugs	$5 generic, $10 brand, $25 brand (non-formulary) copayment. Formulary restrictions may apply. Formulary is subject to change during the plan year.
Durable medical equipment	80%

** HMOs determine the maximum number of inpatient days and outpatient visits for psychiatric and alcohol/substance abuse treatment. Each plan must provide for a minimum of 10 inpatient days and 20 outpatient visits per plan year. These are in addition to detoxification benefits which include diagnosis and treatment of medical complications.*

Some HMOs may provide benefit limitations on a calendar year.

Open Access Plan (OAP) Benefits

The benefits described below represent the minimum level of coverage the OAP is required to provide. Benefits are subject to the limitations outlined in the plan's Certificate of Coverage. It is your responsibility to know and follow the specific requirements of the OAP plan.

Benefit	Tier I 100% Benefit	Tier II 90% Benefit	Tier III (Out-of-Network) 80% Benefit
Plan Year Maximum Benefit	Unlimited	Unlimited	$1,000,000
Lifetime Maximum Benefit	Unlimited	Unlimited	$1,000,000
Annual Out-of-Pocket Maximum • Per Individual Enrollee	$0	$ 600	$1,500
Annual Plan Deductible *Must be satisfied for all services*	$0	$200 Per Enrollee*	$300 Per Enrollee*
Hospital Services			
Inpatient	Full coverage after $150 copayment per admission	90% of network charges for covered services after $200 copayment per admission	80% of U&C for covered services after $300 copayment per admission
Inpatient Psychiatric	Benefits available for care received by providers under Tier II and Tier III	Full coverage after $150 copayment per admission, up to 30 days per plan year	90% of U&C for covered services after $150 copayment per admission, up to 30 days per plan year
Inpatient Alcohol and Substance Abuse	Benefits available for care received by providers under Tier II and Tier III	Full coverage after $150 copayment per admission, up to 10 days rehabilitation per plan year	90% of U&C for covered services after $150 copayment per admission, up to 10 days rehabilitation per plan year
Emergency Room	Full coverage after $100 copayment per admission	90% of network charges for covered services after $100 copayment per admission	80% of U&C for covered services after lesser of $100 copayment per admission, or 50% of U&C
Outpatient Surgery	Full coverage	90% of network charges for covered services	80% of U&C for covered services
Outpatient Psychiatric and Substance Abuse	Benefits available for care received by providers under Tier II and Tier III	Full coverage after $10 copayment, up to 30 visits per plan year	90% of U&C for covered charges after $10 copayment, up to 30 visits per plan year
Diagnostic Lab & X-Ray	Full coverage	90% of network charges for covered services	80% of U&C for covered services
Physician and Other Professional Services			
Physician Office Visits	Full coverage after $10 copayment	90% of network charges for covered services	80% of U&C for covered services
Preventative Services, including Immunizations	Full coverage after $10 copayment	90% of network charges for covered services	Covered In-network only
Well Baby Care	Full coverage after $10 copayment	90% of network charges for covered services	Covered In-network only
Other Services			
Prescription Drugs - Covered in-network only through Wellpoint Pharmacy Management • **Generic -** Full coverage after $5 copayment • **Non-Formulary -** Full coverage after $25 copayment • **Brand -** Full coverage after $10 copayment			
Durable Medical Equipment	Full coverage	90% of network charges for covered services	80% of U&C for covered services
Skilled Nursing Facility	Full coverage	90% of network charges for covered services	Covered In-network only
Transplant Coverage	Full coverage	90% of network charges for covered services	Covered In-network only

*** Annual plan deductible must be met before plan benefits apply. Benefit limits are measured on a plan year. Plan copayments do not count toward the out-of-pocket maximum.**

Important Reminders About Managed Care Plans

Provider Network Changes: Managed care plan provider networks are subject to change. Always call the respective plan to verify participation of particular providers - even if the information is printed in the plan's directory. The provider network is subject to change.

PCPs Leaving a Network: If your PCP leaves the managed care plan's network, you have three options: 1) choose another PCP within that plan; 2) change managed care plans; or 3) enroll in the Teachers' Choice Health Plan. The opportunity to change plans applies only to **Primary Care Physicians leaving the network.** It does not apply to specialists or women's healthcare providers who are not designated Primary Care Physicians.

Out-of-County Managed Care Plans: If you are interested in enrolling in a managed care plan that is not available in your county of residence, contact the plan directly for more information.

Dependents: Eligible dependents who live apart from the Participant's residence for any part of a plan year may be subject to limited service coverage. If you have such a dependent, it is critical to contact the managed care plan that you are considering to understand the plan's guidelines on this type of coverage.

June/July Hospitalizations: If you change health plans and you or your dependents are hospitalized in June, it is recommended you contact both your current plan/PCP and future plan/PCP well in advance.

Psychiatric/Substance Abuse Treatment: Managed care plans determine the maximum number of inpatient days and outpatient visits for psychiatric and alcohol/substance abuse treatment. Plan benefits may vary, but a minimum of 10 inpatient days and 20 outpatient visits are required. These are in addition to detoxification benefits which include diagnosis and treatment of medical complications.

Transplant Services: Both organ and tissue transplant services are eligible for coverage under all participating managed care plans. Each plan establishes its own certification criteria, coverage and provider network. Contact the respective managed care plan for specific information.

Plan Year Limitations: Certain managed care plans may provide benefit limitations on a **calendar year.** In certain situations, the State's plan year may not coincide with the managed care plan's year.

Transition of Services: If you know you are switching plans and you or your dependents are involved in an ongoing course of treatment or have entered the third trimester of pregnancy, it is imperative that you contact the new plan to coordinate the transition of services for your care.

NCQA Accreditation and Managed Care Plans in Bordering States

One way the quality of managed care plans can be judged is through accreditation by an outside agency. **The National Committee for Quality Assurance (NCQA)** is a leader in accrediting managed care plans. The not-for-profit NCQA prides itself on providing purchasers and consumers of managed care with comparative data on plan quality and value.

The higher the level of the accreditation, the more closely the plan meets NCQA standards. Levels include:

Excellent: This highest accreditation status is granted only to those plans that demonstrate levels of service and clinical quality that meet or exceed NCQA rigorous requirements for consumer protection and quality improvement. Plans earning this level must also achieve Health Plan Employer Data and Information Set (HEDIS) results, the highest range of national or regional performance.

Commendable: Awarded to plans demonstrating levels of service and clinical quality that meet or exceed NCQA requirements for consumer protection and quality improvement.

Accredited: Indicates the plan meets most of NCQA basic requirements.

Provisional: Is an indication that a plan's service and clinical quality meet some, but not all, of NCQA basic requirements.

Further information regarding NCQA accreditation, see the chart below or contact NCQA directly at (888) 275-7585 or at their website (http://www.ncqa.org).

Plan Name and Code	Counties in Indiana	Counties in Iowa	Counties in Kentucky	Counties in Missouri	Counties in Wisconsin	NCQA Accreditation
Health Alliance Illinois (Code: BS)	Daviess, Dubois, Gibson, Knox, Martin, Pike, Posey, Spencer, Vanderburgh, Warrick	Lee		Marion, Lewis, Clark		Excellent
Health Alliance HMO (Code: AH)		Scott				Excellent
HealthLink Open Access (Code: CF)	*		*	*		Not Reviewed
HMO Illinois (Code: BY)	Lake, Porter				Kenosha	Excellent
OSF Health Plan (Code: CA)						Excellent
PersonalCare (Code: AS)						Excellent
Unicare HMO (Code: CC)	Lake, Porter					Excellent

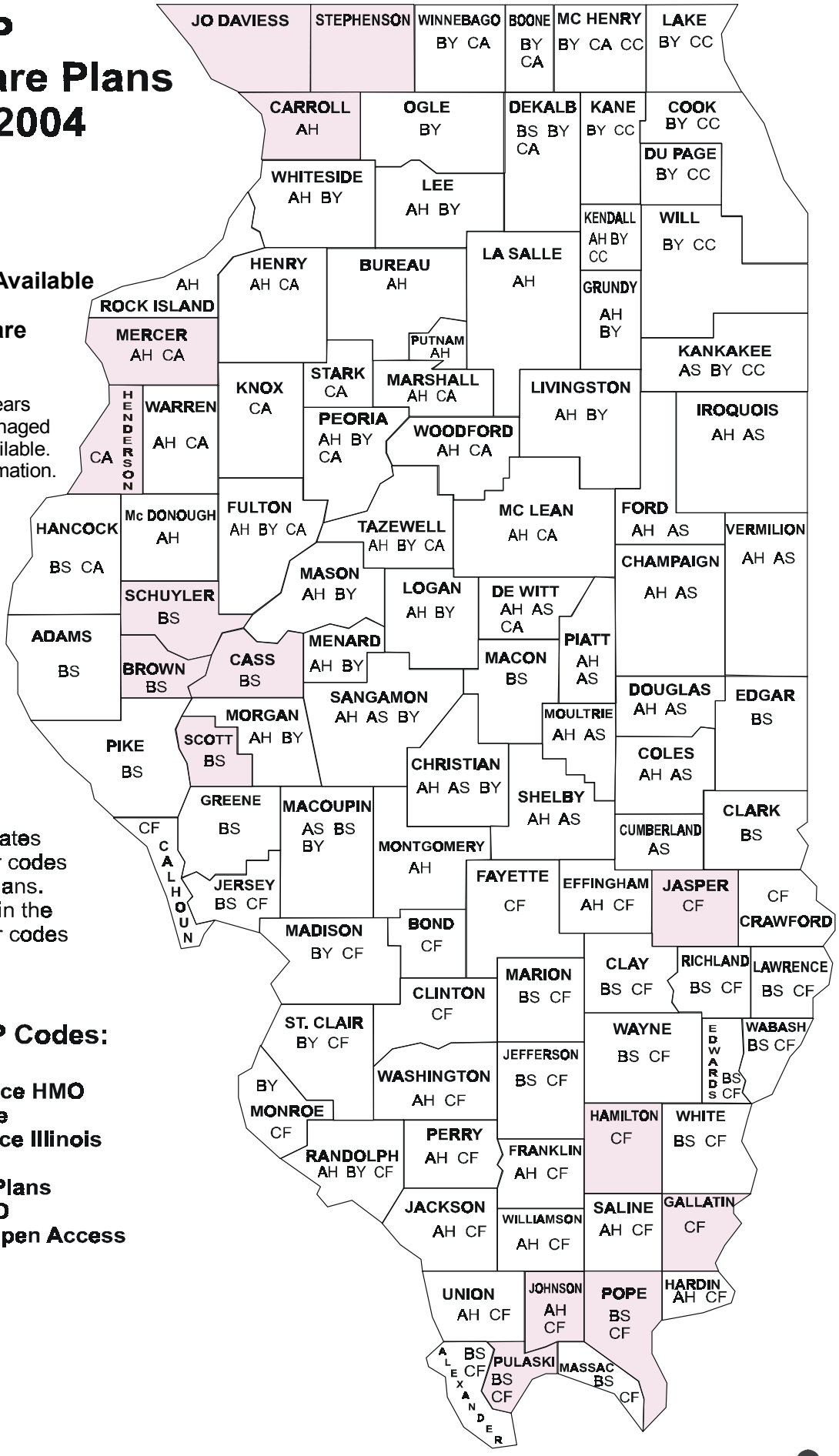
* Counties are too numerous to list. Please contact HealthLink for a complete listing.

TRIP Managed Care Plans For FY 2004

Managed Care Available

No Managed Care Available *

* If a two letter code appears in a shaded county, a managed care provider may be available. Contact the plan for information.



The key below indicates the two-letter carrier codes for managed care plans. Plans are available in the counties where their codes appear.

HMO AND OAP Codes:

AH = Health Alliance HMO
AS = PersonalCare
BS = Health Alliance Illinois
BY = HMO Illinois
CA = OSF Health Plans
CC = UnICare HMO
CF = HealthLink Open Access

The Teachers' Choice Health Plan (TCHP)

TCHP is a medical indemnity plan which offers a comprehensive range of benefits. The TCHP Medical Plan Administrator is CIGNA. Under TCHP, plan participants choose any physician or hospital for general or specialty medical services, and receive enhanced benefits by using a TCHP Preferred Provider Organization (PPO) hospital, the CIGNA Healthcare PPO Network, network pharmacies for prescription drugs and mental health/substance abuse network providers.

Plan Year Maximums and Deductibles

The benefits described in this summary represent the major areas of coverage under TCHP. The plan year is July 1 through June 30 of the following year.	
Lifetime Maximum	$2,000,000
Plan Year Deductible	TCHP Primary Participant (non-Medicare) $250 Medicare Primary Participant $250
Additional Deductibles* ***These are in addition to the plan year deductible.**	Each emergency room visit $250 Non-PPO hospital admission $250 Transplant deductible $100 Note: There is no additional deductible for admission to a PPO hospital.
Skilled Nursing Maximum	Benefits are available up to 100 days each plan year. Benefits cease after the 100th day.

Out-of-Pocket Maximums

There are two separate out-of-pocket maximums: a general and a non-PPO. Coinsurance and deductibles listed below count toward one or the other, but not toward both.

General: **$800 per individual, per plan year**	**Non-PPO:** **$4,000 per individual, per plan year**
Plan Year Deductible ($250) Professional and Physician Coinsurance PPO Facility Coinsurance (20%) Transplant Deductible ($100) Transplant Inpatient and Outpatient Coinsurance (20%) *Standard Hospital Coinsurance (30%) *Standard Hospital Admission Deductible ($250) All Emergency Room Deductibles ($250) Emergency Room Coinsurance (20%) ***When the Notification Administrator grants an exception for a non-PPO admission, or when the Plan Participant does not reside within 25-miles of a TCHP PPO hospital.**	Non-PPO Hospital Deductible ($250) Non-PPO Inpatient Coinsurance (40%) Non-PPO Outpatient Facility Coinsurance (40%)

The following do not apply toward out-of-pocket maximums:

- Prescription Drug benefits or copayments.
- Mental Health/Substance Abuse benefits, coinsurance or copayments.
- Notification penalties.
- Ineligible charges (amounts over U&C and charges for non-covered services).
- The portion ($50) of the Medicare Part A deductible the Plan Participant is responsible to pay.

TCHP - Medical Plan Coverage

Hospital Services	
TCHP Preferred Provider Organization Hospitals and CIGNA Healthcare PPO Network	80% after annual plan deductible. No admission deductible.
Non-Preferred Provider Organization (PPO) Hospital	• $250 per admission deductible. • If the member resides in Illinois or within 25 miles of a TCHP PPO hospital and the member chooses to use a non-PPO and/or voluntarily travels in excess of 25 miles when a TCHP PPO hospital is available within the same travel distance the plan pays 60% after the annual plan deductible. • If the member resides in Illinois and has no TCHP PPO hospital available within 25 miles and voluntarily chooses to travel further than the nearest TCHP PPO hospital, the plan pays 60% after the annual plan deductible. • If the member does not reside in Illinois or within 25 miles of a TCHP PPO hospital, the plan pays 70% after the annual plan deductible.
Outpatient Services	
Lab/X-ray	80% of Usual & Customary (U&C) after annual plan deductible.
Approved Durable Medical Equipment (DME) and Prosthetics	80% of U&C after annual plan deductible. Contact the plan administrator for approval prior to obtaining items.
Licensed Ambulatory Surgical Treatment Center	80% after annual plan deductible.
Professional and Other Services	
CIGNA Healthcare PPO Network	90% of negotiated fee after the annual plan deductible. U&C charges do not apply.
Physician & Surgeon Services	80% of U&C after the annual plan deductible for inpatient, outpatient & office visits.
Transplant Services	
Organ and Tissue Transplants	80% of negotiated fee after $100 transplant deductible. Benefits are not available unless approved by the Notification Administrator (Intracorp). To assure coverage, the transplant candidate **must** contact the Notification Administrator prior to beginning evaluation services.
Coordination with Medicare for Medicare Primary Participants	
After Medicare Part A pays, TCHP will continue to pay all but $50 of the annual Medicare Part A deductible. After Medicare Part B pays, TCHP pays the annual Medicare Part B deductible and the Medicare Part B copay in full. Refer to the Member Handbook for coordination of benefits for mental health/substance abuse.	

TCHP - Notification and Penalties

Notification Requirements

Notification is the telephone call to the Notification Administrator informing them of an upcoming admission to a facility such as a hospital or skilled nursing facility, or for a specified outpatient procedure. Notification is the plan participant's responsibility and is a method to avoid monetary penalties and maximize benefits.

For notification procedures for mental health/substance abuse services, see the Benefits Handbook section entitled Mental Health/Substance Abuse.

Notification is required for all plan participants including those who may no longer have benefits available from other primary payer insurance or Medicare. Allow a minimum of two business days for review. Failure to notify the Notification Administrator within the required time limits will result in a $1,000 penalty and the risk of incurring non-covered charges for services not deemed to be medically necessary.

A "reference number" will be assigned and should be maintained in the plan participant's records. This number serves as a reference should there be any questions regarding notification. However, it is not a guarantee of benefits.

Upon notification, a medically-qualified reviewer will contact the plan participant's physician or provider to obtain specific medical information, evaluate the procedure, setting and anticipated initial length of stay for medical appropriateness, and determine whether a second opinion is required.

Notification is required for the following:

- **Elective Surgical or Non-Emergency Admission** - At least seven days before admission, call the Notification Administrator.
- **Maternity** - It is recommended that the notification process occur as early in the pregnancy as possible in order to enable the Notification Administrator to assist in monitoring the progress of the pregnancy. Notification should occur no later than the third month. Notification of a maternity admission is not automatic enrollment of the newborn. Contact the Teachers' Retirement System to enroll the newborn.
- **Skilled Nursing - In a Skilled Nursing Facility, Extended Care Facility or Nursing Home** - At least seven days before admission, call the Notification Administrator. A review will be conducted to determine if the services are skilled in nature.
- **Emergency or Urgent Admission** - The plan participant or physician must phone the Notification Administrator within two business days after the admission.
- **Outpatient Procedures** - It is necessary to call the Notification Administrator before receiving imaging (MRI, PET, SPECT and CAT Scan), allergy testing, colonoscopy and endoscopy services.
- **Potential Transplants** - To ensure maximum benefits are available, potential transplant candidates should provide notification at the first indication that a transplant may be necessary. Benefits are available only if authorized by the Notification Administrator.
- **Infertility Treatment** - A written predetermination of benefits must be obtained from the Medical Plan Administrator prior to beginning infertility treatment. This applies to both medical and prescription benefits. Upon submission of the required documentation, a letter of denial or approval will be mailed to the plan participant. Refer to page 41 of your Benefits Handbook for more information. Please allow a minimum of 5 business days from receipt of all necessary documentation by the Notification Administrator to determine if the treatment is approved or denied.

To satisfy the notification requirement, you can call seven days a week, 24 hours a day:

INTRACORP/CIGNA (800) 962-0051
(800) 526-0844
(TDD/TTY)

TCHP - Prescription Drug Plan

Prescription drug benefits are independent of other medical services and are not subject to the plan year deductible or the medical out-of-pocket maximums. The Prescription Drug Plan includes both in-network and out-of-network benefits. Most drugs purchased with a prescription from a physician or dentist are covered. No over-the-counter drugs will be covered, even if purchased with a prescription.

Infertility Prescription Benefits - A written pre-determination of benefits must be obtained from the Medical Plan Administrator (CIGNA) prior to beginning infertility treatment. This applies to both medical and prescription benefits (see page 41 of the Benefits Handbook). Upon submission of the required documentation, a letter of denial or approval will be mailed by the Medical Plan Administrator .

The Prescription Drug Plan Administrator must confirm that a pre-determination of benefits has been approved before infertility medication can be dispensed at a retail pharmacy. This may take additional time. If a pre-determination is not on file, the plan participant will be directed to contact the Medical Plan Administrator to start the process. This will slow receipt of any approved medication.

When ordering infertility medication through the Mail Order Pharmacy, a copy of the pre-determination letter from the Medical Plan Administrator must accompany any prescription in order for these medications to be filled. If the approved pre-determination letter is not enclosed with the infertility medication prescription, the plan participant will be directed to contact the Medical Plan Administrator to start the process. This will slow receipt of any approved medication.

In-Network Benefits

The pharmacy network consists primarily of retail pharmacies which accept the copayment and electronically transmit the prescription claim for processing. The Member identification number, which ends in 1402, is printed on the ID card. For the most up-to-date information on network pharmacies, call the Prescription Drug Plan Administrator found on page 28.

In-network benefits when using the Plan Participant ID Card/Number:

- No plan year deductibles; no claim forms to file.
- Flat Copayments (1 to 30-day supply):
  - Generic $ 7.00
  - Formulary Brand $14.00
  - Non-Formulary Brand $28.00
- The maximum days supply available at one fill is 60 days. The copayments described above will double for any prescription exceeding 30 days.
- When the pharmacy dispenses a brand drug for any reason, and a generic is available, the plan participant must pay the cost difference between the brand product and the generic product, plus the generic copayment of $7.00.
- If only a brand drug is available, the copayment will be $14.00 or $28.00.
- When the price of a prescription is lower than the copayment, the pharmacist will collect the lower amount.

When medication is purchased at an in-network pharmacy <u>without</u> presentation of the ID Card/Number, the plan participant will be charged the full retail cost of the medication. A paper claim for reimbursement of the cost must then be sent to the Prescription Drug Plan Administrator. The claim will be processed as if the prescription was filled at an out-of-network pharmacy (see Out-of-Network Benefits).

Out-of-Network Benefits

Prescription drugs may be purchased at out-of-network pharmacies. Plan participants must pay all charges at the time of purchase and file a paper claim form with the Prescription Drug Plan Administrator. Reimbursement will be at the applicable brand or generic **in-network** price minus the appropriate in-network copayment. In most cases, the cost of the prescription drugs

will be higher when not using network pharmacies. Claim forms are available from the Prescription Drug Plan Administrator.

Mail Service Program

Maintenance medications are available through mail order at the following copayments:

– Flat Copayments (90-day supply):

- Generic $14.00
- Formulary Brand $28.00
- Non-Formulary Brand $56.00

Contact the Prescription Drug Plan Administrator for mail order forms and information.

Specialty Pharmacy Services

Some medications are only dispensed from the Prescription Drug Plan's Specialty Pharmacy. This pharmacy specializes in the delivery of medications for specific diseases. The types of medications dispensed from the Specialty Pharmacy are for conditions such as: Multiple Sclerosis, Hepatitis B and C, Arthritis, Immune Deficiency and Hemophilia. Medication is usually shipped within 24 hours of receipt of the request; quantities are limited to 30-days or less. For additional information, contact the Prescription Drug Plan Administrator at www.caremark.com or call 1-800-237-2767.

Coordination of Benefits

This Plan coordinates with Medicare and other group plans. However, the appropriate copayment will always be applied.

Medicare Covered Prescriptions

When a plan participant is enrolled in Medicare Part B and Medicare is primary, Medicare provides coverage for certain prescriptions, including diabetic test strips and lancets. Medicare approved retail pharmacies will submit claims for Medicare covered prescriptions directly to Medicare. At the time of purchase, plan participants will generally be responsible for the 20% not covered by Medicare.

Caremark's Mail Order Pharmacy will also submit claims to Medicare for Medicare covered prescriptions, charging only the 20% of the Medicare allowed amount. This process cannot be initiated until the plan participant has signed an assignment of benefit form and mailed it to the Prescription Drug Plan Administrator. To obtain these forms, contact the Prescription Drug Plan Administrator at 1-866-804-5880.

Upon receipt of the Medicare Explanation of Benefits (EOMB), plan participants may submit a paper claim for any reimbursement due (usually a portion of the 20%). The applicable copayment is always applied.

The Prescription Drug Plan Administrator has established a special Medicare Customer Service Team (866-804-5880) to provide forms and answer questions regarding Medicare Coordination of Benefits. For answers to questions about eligibility for Medicare Part A, Part B, or to apply for Medicare, call the Social Security Administration at 1-800-772-1213 or 1-800-325-0778 (TDD/TTY).

Exclusions

The Plan reserves the right to exclude or limit coverage of specific prescription drugs or supplies.

TCHP- CIGNA HealthCare PPO Networks

TCHP non-Medicare Participants have available **nationwide** CIGNA HealthCare PPO providers, hospitals and facilities. An enhanced 90% benefit for professional fees, hospital and facility services is available by using a participating network provider. The questions and answers below provide more information about this benefit feature. If you have additional questions, call the Group Insurance Division, see page 28.

What is the CIGNA HealthCare PPO Network?

The CIGNA HealthCare PPO Network is a nationwide network of physicians, hospitals and facilities that have agreed to participate at negotiated rates offering members an enhanced benefit.

What are the advantages of using a CIGNA HealthCare PPO Network provider?

The advantages of using providers participating in the network are that benefits for covered services are paid at 90% of a negotiated fee and usual and customary limits will not be applied.

How do I access services from a CIGNA HealthCare PPO Network provider?

Just make an appointment with a network provider and present your Teachers' Choice Health Plan identification card at the time of service.

What if I do not use a CIGNA HealthCare PPO Network provider?

Standard plan benefits, coinsurance levels, and usual and customary limits apply.

How can I find out which providers are participating in the CIGNA HealthCare PPO Network?

Access the participating provider list on the website at:

http://provider.healthcare.cigna.com/soi.html.
Or, call CIGNA at (800) 962-0051.

TCHP - Hospital Preferred Provider Organizations

Chicagoland Area (Cook, DuPage & Lake Counties)

Advocate Bethany Hospital, Chicago
Advocate Christ Hospital & Med. Ctr., Oak Lawn
Advocate Good Samaritan Hosp., Downers Grove
Advocate Good Shepherd Hospital, Barrington
Advocate Illinois Masonic Medical Center, Chicago
Advocate Lutheran General Hospital, Park Ridge
Advocate South Suburban Hospital, Hazel Crest
Advocate Trinity Hospital, Chicago
Alexian Brothers Medical Ctr., Elk Grove Village

Central DuPage Hospital, Winfield
Children's Memorial Hospital, Chicago
Condell Medical Center, Libertyville
Cook County Hospital, Chicago

Edward Hospital, Naperville
Elmhurst Memorial Hospital, Elmhurst
Evanston Northwestern Healthcare, Evanston

Glen Oaks Hospital, Glendale Heights
Glenbrook Hospital, Glenview
Gottlieb Memorial Hospital, Melrose Park
Grant Community Hospital, Chicago

Highland Park Hospital, Highland Park
Hinsdale Hospital, Hinsdale
Holy Cross Hospital, Chicago
Holy Family Medical Center, Des Plaines

Ingalls Memorial Hospital, Harvey

Jackson Park Hospital, Chicago

LaGrange Memorial Hospital, LaGrange
Lake Forest Hospital, Lake Forest
LaRabida Children's Hospital, Chicago
Little Company of Mary Hospital, Evergreen Park
Loretto Hospital, Chicago
Louis A. Weiss Memorial Hospital, Chicago
Loyola University Medical Center, Maywood

MacNeal Memorial Hospital, Berwyn
Marianjoy Rehabilitation Hospital, Wheaton
Mercy Hospital & Medical Center, Chicago
Methodist Hospital of Chicago, Chicago
Michael Reese Hospital & Medical Ctr., Chicago
Mt. Sinai Hospital, Chicago

Northwest Community Hospital, Arlington Heights
Northwestern Memorial Hospital, Chicago
Norwegian American Hospital, Chicago

Oak Forest Hospital of Cook County, Oak Forest
Oak Park Hospital, Oak Park
Our Lady of the Resurrection Med. Center, Chicago

Palos Community Hospital, Palos Heights
Provena St. Therese Medical Center, Waukegan
Provident Hospital of Cook County, Chicago

Rehabilitation Institute of Chicago, Chicago
Resurrection Medical Center, Chicago
RML Specialty Hospital, Hinsdale
Roseland Community Hospital Assn., Chicago
Rush North Shore Medical Center, Skokie
Rush Pres-St. Luke's Medical Center, Chicago

Schwab Rehabilitation Hospital, Chicago
South Shore Hospital, Chicago
SSM St. Francis Hosp. & Hlth. Ctr., Blue Island
St. Alexius Medical Center, Hoffman Estates
St. Anthony Hospital, Chicago
St. Bernard Hospital & Health Care Center, Chicago
St. Elizabeth Hospital, Chicago (closing in late 2003)
St. Francis Hospital, Evanston
St. James Hospital & Health Center, Chicago Hts.
St. James Hospital & Health Center, Olympia Fields
St. Joseph Hospital, Chicago
St. Margaret Mercy Healthcare Ctr., Hammond, IN
St. Margaret Mercy Healthcare Center, Dyer, IN
St. Mary of Nazareth Hospital Center, Chicago
Swedish Covenant Hospital, Chicago

The Community Hospital, Munster, IN
Thorek Hospital & Medical Center, Chicago

University of Chicago Hospital, Chicago
University of Illinois Medical Center, Chicago

Victory Memorial Hospital, Waukegan

West Suburban Hospital Medical Center, Oak Park
Westlake Community Hospital, Melrose Park

TCHP - Hospital Preferred Provider Organizations

Northern Illinois

CGH Medical Center, Sterling
Children's Hospital of Wisconsin, Milwaukee
Copley Medical Center, Aurora

Delnor Community Hospital, Geneva
DeWitt Community Hospital, DeWitt, IA

Freeport Memorial Hospital, Freeport

Genesis Medical Center East, Davenport, IA
Genesis Medical Center West, Davenport, IA

Hammond-Henry District Hospital, Geneseo
Harvard Memorial Hospital, Inc., Harvard

Illini Hospital, Silvis

Katherine Shaw Bethea Hospital, Dixon
Kishwaukee Community Hospital, DeKalb

Memorial Medical Center, Woodstock
Mendota Community Hospital, Mendota
Mercer County Hospital, Aledo
Mercy Medical Center, Clinton, IA
Morris Hospital, Morris
Morrison Community Hospital, Morrison

Northern Illinois Medical Center, McHenry

Provena Mercy Center, Aurora
Provena St. Joseph Hospital, Elgin
Provena St. Joseph Medical Center, Joliet
Provena St. Mary's Hospital, Kankakee

Riverside Medical Center, Kankakee
Rochelle Community Hospital, Rochelle
Rockford Memorial Hospital, Rockford

Saint Anthony Medical Center, Rockford
Sherman Hospital, Elgin
Silver Cross Hospital, Joliet
St. Anthony Medical Center, Crown Point, IN
Swedish American Hospital, Rockford

The Monroe Clinic, Monroe, WI
Trinity Med. Ctr., North Campus, Davenport, IA
Trinity Medical Center, 7th St., Moline
Trinity Medical Ctr., West Campus, Rock Island

Univ. of Wisconsin Hospital, Madison, WI

Valley West Community Hospital, Sandwich

TCHP - Hospital Preferred Provider Organizations

Central Illinois

Abraham Lincoln Memorial Hospital, Lincoln
Blessing Hospital, Quincy
BroMenn Regional Medical Center, Bloomington

Carle Foundation Hospital, Urbana
Carlinville Area Hospital, Carlinville
Community Hospital of Ottawa, Ottawa
Comm. Med. Ctr. of Western Illinois, Monmouth
Community Memorial Hospital, Staunton

Decatur Memorial Hospital, Decatur
Doctors Hospital, Springfield
Dr. John Warner Hospital, Clinton

Eureka Community Hospital, Eureka

Galesburg Cottage Hospital, Galesburg
Gibson Community Hospital, Gibson City
Graham Hospital, Canton

Hillsboro Area Hospital, Hillsboro
Hoopeston Comm. Memorial Hosp., Hoopeston

Illini Community Hospital, Pittsfield
Illinois Valley Community Hospital, Peru
Iroquois Memorial Hospital, Watseka

Jersey Community Hospital, Jerseyville
Julia Rackley Perry Memorial Hospital, Princeton

Keokuk Area Hospital, Keokuk, IA

Mason District Hospital, Havana
McDonough District Hospital, Macomb
Memorial Hospital Association, Carthage
Memorial Medical Center, Springfield
Methodist Medical Center of Illinois, Peoria

Pana Community Hospital, Pana
Paris Community Hospital, Paris
Passavant Memorial Area Hospital, Jacksonville
Pekin Hospital, Pekin
Proctor Hospital, Peoria
Provena Covenant Medical Center, Urbana
Provena United Samaritans Med. Ctr., Danville

Saint Francis Medical Center, Peoria
Saint James Hospital, Pontiac
Sarah Bush Lincoln Health Center, Mattoon
Sarah D. Culbertson Mem. Hosp., Rushville
Shelby Memorial Hospital, Shelbyville
St. Francis Hospital, Litchfield
St. John's Hospital, Springfield
St. Joseph Medical Center, Bloomington
St. Margaret's Hospital, Spring Valley
St. Mary Medical Center, Galesburg
St. Mary's Hospital, Decatur
St. Mary's Hospital, Streator
St. Vincent Memorial Hospital, Taylorville

The John & Mary E. Kirby Hospital, Monticello
Thomas H. Boyd Memorial Hospital, Carrollton

TCHP - Hospital Preferred Provider Organizations

Southern Illinois and Metro-East

Alton Memorial Hospital, Alton
Anderson Hospital, Maryville

Barnes-Jewish Hospital, St. Louis
Barnes-Jewish St. Peter's Hospital, St. Peters, MO
Barnes-Jewish West County Hospital, Creve Coeur

Christian Hospital, NE, St. Louis
Christian Hospital, NW, Florissant
Clay County Hospital, Flora
Crawford Memorial Hospital, Robinson
Crossroads Comm. Hospital, Mt. Vernon

Des Peres Hospital, St. Louis

Edward A. Utlaut Hospital, Greenville

Fairfield Memorial Hospital, Fairfield
Fayette County Hospital, Vandalia
Ferrell Hospital, Eldorado
Forest Park Hospital, St. Louis

Gateway Regional Medical Center, Granite City
Good Samaritan Hospital, Vincennes, IN
Good Samaritan R.H.C., Mt. Vernon

Hamilton Memorial Hospital, McLeansboro
Hardin County General Hospital, Rosiclare
Harrisburg Medical Center, Harrisburg
Heartland Regional Medical Center, Marion
Herrin Hospital, Herrin

Lawrence County Memorial Hospital, Lawrenceville
Lourdes Hospital, Paducah, KY

Marshall Browning Hospital, DuQuoin
Massac Memorial Hospital, Metropolis
Memorial Hospital, Belleville
Memorial Hospital, Chester
Memorial Hospital of Carbondale, Carbondale
Missouri Baptist Medical Center, St. Louis

Pinckneyville Community Hosp., Pinckneyville

Red Bud Hospital, Red Bud
Richland Memorial Hospital, Olney

Saint Anthony's Health Center, Alton
Saint Clare's Hospital, Alton
Saint Francis Medical Center, Cape Girardeau, MO
Salem Township Hospital, Salem
South Pointe Hospital, St. Louis
Southeast Missouri Hospital, Cape Girardeau, MO
Sparta Community Hospital, Sparta
SSM Cardinal Glennon Children's Hosp., St. Louis
SSM DePaul Health Center, Bridgeton, MO
SSM Rehabilitation Institute, St. Louis (all sites)
SSM St. Mary's Health Center, Richmond Heights
St. Alexius Hospital, St. Louis
St. Anthony's Medical Center, St. Louis
St. Anthony's Memorial Hospital, Effingham
St. Elizabeth's Hospital, Belleville
St. John's Mercy Medical Center, St. Louis
St. Joseph's Hospital, Highland
St. Joseph's Hospital, Breese
St. Joseph Memorial Hospital, Murphysboro
St. Louis Children's Hospital, St. Louis
St. Louis University Hospital, St. Louis
St. Luke's Episcopal Presbyterian Hosp., Chesterfield
St. Mary's Hospital, Centralia
St. Mary's Hospital of E. St. Louis, E. St. Louis, IL

Touchette Regional Hospital, Centreville

Union County Hospital District, Anna

Wabash General Hospital, Mt. Carmel
Washington County Hospital, Nashville
White County Medical Center, Carmi

Health Insurance Portability and Accountability Act (HIPAA)

Title II of the federally enacted Health Insurance Portability and Accountability Act of 1996, commonly referred to as HIPAA, was designed to protect the confidentiality and security of health information and to improve efficiency in healthcare delivery. HIPAA standards protect the confidentiality of medical records and other personal health information, limit the use and release of private health information, and restrict disclosure of health information to the minimum necessary.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective April 14, 2003

The State of Illinois, Department of Central Management Services, Bureau of Benefits (Bureau) is charged with the administration of the self-funded plans available through the State Employees Group Insurance Act of 1971 including the Teachers' Choice Health Plan. The term "we" in this Notice means the Bureau and our Business Associates (health plan administrators).

We are required by federal and state law to maintain the privacy of your Protected Health Information (PHI). We are also required by law to provide you with this Notice of our legal duties and privacy practices concerning your PHI. For uses and disclosures not covered by this Notice, we will seek your written authorization. You may revoke an authorization at any time; however, the revocation will only affect future uses or disclosures.

The Bureau contracts with Business Associates to provide services including claim processing, utilization review, behavioral health services and prescription drug benefits. You may not have coverage with all of our Business Associates. These Business Associates receive health information protected by the privacy requirements of the Health Insurance Portability and Accountability Act and act on behalf of the Bureau in performing their respective functions. When we seek help from individuals or entities who are not part of the Bureau in our treatment, payment, or health care operations activities, we require those persons to follow this Notice unless they are already required by law to follow the federal privacy rule. CIGNA HealthCare is the Medical Plan Administrator. Intracorp (a CIGNA HealthCare Affiliate) is the Notification and Medical Case Management Administrator. Caremark is the Pharmacy Benefit Plan Administrator. Magellan Behavioral Health is the Mental Health and Substance Abuse Plan Administrator. If you have insured health coverage, such as an HMO, you will receive a Notice from the respective plan administrator regarding its Privacy Practices.

How We May Use or Disclose Your PHI

Treatment: We may use or disclose PHI to health care providers who take care of you. For example, we may use or disclose PHI to assist in coordinating health care or services provided by a third party.

We may also use or disclose PHI to contact you and tell you about alternative treatments, or other health-related benefits we offer. If you have a friend or family member involved in your care, with your express or implied permission, we may give them PHI about you.

Payment: We use and disclose PHI to process claims and make payment for covered services you receive under your benefit plan. For example, your provider may submit a claim for payment. The claim includes information that identifies you, your diagnosis, and your treatment.

Health Care Operations: We use or disclose PHI for health care operations. For example, we may use your PHI for customer service activities and to conduct quality assessment and improvement activities.

Appointment Reminders: Through a Business Associate, we may use or disclose PHI to remind you of an upcoming appointment.

Legal Requirements

We may use and disclose PHI **as required or authorized by law.** For example, we may use or disclose your PHI for the following reasons:

Public Health: We may use and disclose PHI to prevent or control disease, injury or disability, to report births and deaths, to report reactions to medicines or medical devices, to notify a person who may have been exposed to a disease, or to report suspected cases of abuse, neglect or domestic violence.

Health Oversight Activities: We may use and disclose PHI to state agencies and federal government authorities when required to do so. We may use and disclose your health information in order to determine your eligibility for public benefit programs and to coordinate delivery of those programs. For example, we must give PHI to the Secretary of Health and Human Services in an investigation into compliance with the federal privacy rule.

Judicial and Administrative Proceedings: We may use and disclose PHI in judicial and administrative proceedings. In some cases, the party seeking the information may contact you to get your authorization to disclose your PHI.

Law Enforcement: We may use and disclose PHI in order to comply with requests pursuant to a court order, warrant, subpoena, summons, or similar process. We may use and disclose PHI to locate someone who is missing, to identify a crime victim, to report a death, to report criminal activity at our offices, or in an emergency.

Avert a Serious Threat to Health or Safety: We may use or disclose PHI to stop you or someone else from getting hurt.

Work-Related Injuries: We may use or disclose PHI to workers' compensation or similar programs in order for you to obtain benefits for work-related injuries or illness.

Coroners, Medical Examiners, and Funeral Directors: We may use or disclose PHI to a coroner or medical examiner in some situations. For example, PHI may be needed to identify a deceased person or determine a cause of death. Funeral directors may need PHI to carry out their duties.

Organ Procurement: We may use or disclose PHI to an organ procurement organization or others involved in facilitating organ, eye, or tissue donation and transplantation.

Release of Information to Family Members: In an emergency, or if you are not able to provide permission, we may release limited information about your general condition or location to someone who can make decisions on your behalf.

Armed Forces: We may use or disclose the PHI of Armed Forces personnel to the military for proper execution of a military mission. We may also use and disclose PHI to the Department of Veterans Affairs to determine eligibility for benefits.

National Security and Intelligence: We may use or disclose PHI to maintain the safety of the President or other protected officials. We may use or disclose PHI for national intelligence activities.

Correctional Institutions and Custodial Situations: We may use or disclose PHI to correctional institutions or law enforcement custodians for the safety of individuals at the correctional institution, those who are responsible for transporting inmates, and others.

Research: You will need to sign an authorization form before we use or disclose PHI for research purposes except in limited situations where special approval has been given by an Institutional Review or Privacy Board. For example, if you want to participate in research or a clinical study, an authorization form must be signed.

Fundraising and Marketing: We do not undertake fundraising activities. We do not release PHI to allow other entities to market products to you.

Plan Sponsors: Your employer is not permitted to use the PHI for any purpose other than the administration of your benefit plan. If you are enrolled through a unit of local government, we may disclose summary PHI to your employer, or someone acting on your employer's behalf, so that it can monitor, audit or otherwise administer the employee health benefit plan that the employer sponsors and in which you participate.

Illinois Law: Illinois law also has certain requirements that govern the use or disclosure of your PHI. In order for us to release information about mental health treatment, genetic information, your AIDS/HIV status, and alcohol or drug abuse treatment, you will be required to sign an authorization form unless Illinois law allows us to make the specific type of use or disclosure without your authorization.

Your Rights

You have certain rights under federal privacy laws relating to your PHI. To exercise these rights, you must submit your request in writing to the appropriate plan administrator. These plan administrators are as follows:

For the Medical Plan Administrator and Notification/Medical Case Management Benefits:

CIGNA HealthCare
Privacy Office
P.O. Box 5400
Scranton, PA 18503
800-762-9940

For Pharmacy Benefits:

Caremark, Inc.
Privacy Officer
2211 Sanders Road
Northbrook, IL 60062
800-559-4700

For Mental Health and Substance Abuse Benefits:

Magellan Behavioral Health
Privacy Official
10 S. Riverside Plaza
11th Floor
Chicago, IL 60604
800-424-4020

Restrictions: You have a right to request restrictions on how your PHI is used for purposes of treatment, payment and health care operations. We are not required to agree to your request.

Communications: You have a right to receive confidential communications about your PHI. For example, you may request that we only call you at home or that we send your mail to another address. If your request is put in writing and is reasonable, we will accommodate it. If you feel you may be in danger, just tell us you are "in danger" and we will accommodate your request.

Inspect and Access: You have a right to inspect information used to make decisions about you. This information includes billing and medical record information. You may not inspect your record in some cases. If your request to inspect your record is denied, we will send you a letter letting you know why and explaining your options.

You may copy your PHI in most situations. If you request a copy of your PHI, we may charge you a fee for making the copies. If you ask us to mail your records, we may also charge you a fee for mailing the records.

Amendment of your Records: If you believe there is an error in your PHI, you have a right to make a request that we amend your PHI. We are not required to agree with your request to amend. We will send you a letter stating how we handled your request.

Accounting of Disclosures: You have a right to receive an Accounting of Disclosures that we have made of your PHI for purposes other than treatment, payment, and health care operations, or disclosures made pursuant to your authorization. We may charge you a fee if you request more than one Accounting in a 12-month period.

Copy of Notice and Changes to the Notice: You have a right to obtain a paper copy of this Notice, even if you originally obtained the Notice electronically. We are required to abide with terms of the Notice currently in effect; however, we may change this Notice. Changes to the Notice are applicable to the health information we already have. If we materially change this Notice, you will receive a new Notice within sixty (60) days of the material change. You can also access a revised Notice on our website at: www.state.il.us/cms/employee/grpins/.

Complaints: If you feel that your privacy rights have been violated, you may file a complaint by contacting the Privacy Officer of the respective Plan Administrator. If the Privacy Officer does not handle your complaint or request adequately, please contact the Central Management Services Privacy Officer at the Office of the Chief Counsel, Privacy Officer, Department of Central Management Services, 401 South Spring, Room 720, Springfield, Illinois 62706, 217-782-9669. We will not retaliate against you for filing a complaint. You may also file a complaint with the Secretary of Health and Human Services in Washington, DC if you feel your privacy rights have been violated.

Plan Administrators

Only **general** plan questions should be directed to the CMS Group Insurance Division or Teachers' Retirement System. Direct all specific claim inquiries to the plan administrators.

Healthcare Plan Name/Administrator	Toll-Free Telephone Number	TDD / TTY Number	Web Site Address
Health Alliance HMO	(800) 851-3379	(217) 337-8137	www.healthalliance.org
Health Alliance Illinois	(800) 851-3379	(217) 337-8137	www.healthalliance.org
HealthLink OAP	(800) 624-2356	(800) 624-2356, ext 6280	www.healthlink.com
HMO Illinois	(800) 868-9520	(800) 888-7114	www.bcbsil.com
OSF Health Plan	(888) 716-9138	(888) 817-0139	www.osfhealthplans.com
PersonalCare	(800) 431-1211	(217) 366-5551	www.personalcare.org
Unicare HMO	(888) 234-8855	(312) 234-7770	www.unicare.com

Plan Component	Contact For:	Administrator's Name and Address	Customer Service Phone Numbers
Teachers' Choice Health Plan (TCHP) Medical Plan Administrator	Medical service information, claim forms, ID cards, claim filing/resolution , and pre-determination of benefits.	**CIGNA** Group Number 2457482 CIGNA HealthCare P.O. Box 5200 Scranton, PA 18505-5200	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com.soi.html
TCHP Notification and Medical Case Management Administrator	Notification prior to hospital services. Non-compliance penalty of $1,000 applies. See page 16 for more information.	**Intracorp, Inc.** (no address required)	(800) 962-0051 (nationwide) (800) 526-0844 (TDD/TTY) http://provider.healthcare.cigna.com.soi.html
TCHP Prescription Drug Plan Administrator	Information on prescription drug coverage, pharmacy network, mail order drug, specialty pharmacy, ID cards and claim forms filing.	**Caremark, Inc.** Group Number 1402 **Paper Claims:** P.O. Box 686005 San Antonio, TX 78268-6005 **Mail Order Prescriptions:** P.O. Box 7624 Mt. Prospect, IL 60056-7624	(866) 212-4751 (nationwide) (800) 231-4403 (TDD/TTY) www.caremark.com
Member Assistance Program - TCHP MH/SA Plan Administrator	Mental Health and Substance Abuse notification, authorization, claim forms and claim filing/resolution.	**Magellan Behavioral Health** Group Number 2457482 P.O. Box 909782 Chicago, IL 60690	(800) 513-2611 (nationwide) (800) 526-0844 (TDD/TTY) www.MagellanAssist.com
General Information	General information on theTRIP health plans.	**CMS Group Insurance Division** 600 Stratton Building Springfield, IL 62706	(217) 782-2548 (800) 442-1300 (800) 526-0844 (TDD/TTY)
	General eligibility and enrollment information.	**TRS** 2815 W. Washington P.O. Box 19253 Springfield, IL 62794-9253	(800) 877- 7896 (217) 753- 0329 (TDD/TTY)

CMS ILLINOIS DEPARTMENT OF CENTRAL MANAGEMENT SERVICES

TRS Teachers' Retirement System of the State of Illinois
2815 West Washington, P.O. Box 19253
Springfield, Illinois 62794-9253
(800) 877-7896
TDD (217)753-0329
Retirement Security for Illinois Educators

TEACHERS' RETIREMENT INSURANCE PROGRAM (TRIP)

TRIP BENEFIT CHOICE APPLICATION

Effective July 1, 2003 – June 30, 2004

(Please print or type.)

Annuitant (Applicant) Information -- Return to TRS only if you wish to change your coverage.

1 Last name	First name	Middle initial	2 Social Security number

3 Street address	4 City	State	ZIP code

5 County of residence	6 Home telephone (include area code)	7 Gender ☐ M ☐ F	8 Date of birth (MM/DD/YYYY)

9 Effective date of retirement	10 Marital status	11 Deferred coverage	12 Effective date of deferred coverage
N/A	☐ M ☐ S	N/A	N/A

Dependent Information – *Complete only if you are enrolling dependents.*

13 Spouse's first name	14 Spouse's last name	15 Spouse's gender ☐ M ☐ F

16 Date of birth *(MM/DD/YYYY)*	17 Social Security number	18. Spouse's effective date of retirement N/A

19 Relationship of other dependents	20 Date of birth	21 Medicare (Y) Yes	(N) No	22 Last name	23 First name	24 Social Security number

25 Medicare – *Complete if you are eligible for Medicare. Please attach a copy of your Medicare card.*

Covered person's name	Part A effective date	Part A free (Y) Yes	(N) No	Part B effective date	Medicare number

26 Desired Coverage – *Check Medical Indemnity or Managed Care* ☐ **Medical Indemnity** ☐ **Managed Care**

Annuitants and dependents must select the same coverage. For each person enrolling in TRIP, check the appropriate plan coverage below based on Medicare eligibility, age, or both. If you select Managed Care, also complete for each person the primary care physician's name and six-digit number, the clinic name, and the Managed Care Plan name and code.

Covered person's name	Plan coverage				If Managed Care (HMO or OAP), indicate primary care physician's and/or clinic's name		
	65+ Medicare	65+ no Medicare	Under 65	Under 23	Physician's name	Physician's number	Clinic's name
					Managed Care Plan name and code		

27 Other Group Health Coverage

Policyholder's name	Insurance company's name	Insurance company's address

I hereby apply for the Teachers' Retirement Insurance Program (TRIP). All information furnished by me on this application is true and complete to the best of my knowledge. I authorize the Teachers' Retirement System to deduct the cost of this coverage from my annuity. I agree to abide by all rules and to furnish any additional information requested. My signature below confirms that I understand all the options selected and authorize the release of information to the health plan I select and the State of Illinois. This authorization will remain in effect until further written notice.

28 Signature (annuitant or legal representative)	Date

TEACHERS' RETIREMENT INSURANCE PROGRAM (TRIP) INSTRUCTIONS

(Return to TRS *only* if you wish to change your coverage.)

COMPLETE AND MAIL TO:
Teachers' Retirement System of the State of Illinois
2815 West Washington Street
Post Office Box 19253
Springfield, IL 62794-9253

FOR ASSISTANCE IN COMPLETING THIS FORM, CALL:
Teachers' Retirement System
Counseling Department
(800) 877-7896

1-8. **THIS INFORMATION REFERS TO THE ANNUITANT.** Please provide the requested information. Your name must be the same name shown on your monthly check.

9. This information is not applicable.

10. Check your marital status.
M = Married S = Single

11-12. This information is not applicable.

13–15. **THIS INFORMATION REFERS TO THE SPOUSE.** Please provide the requested information if enrolling your spouse in TRIP.

16. When filling in your spouse's date of birth, enter it as a two-digit month, a two-digit day and a four-digit year.
Example: 02/09/1940

17. Include your spouse's Social Security number.

18. This information is not applicable.

19. **THIS INFORMATION REFERS TO OTHER DEPENDENTS.** Children over 19 years of age (unless handicapped or attending school), sisters, brothers, or in-laws are not eligible for the insurance program.

20. Include the birth date of each dependent. Enter it as a two-digit month, a two-digit day and a four-digit year.
Example: 02/09/1940

21. Indicate whether each dependent is covered by Medicare at the time of his or her effective date of coverage. Use a "Y" for yes or an "N" for no.

22. Complete this area if your dependent's last name is different from your last name.

23. Fill in each dependent's given first name.

24. Include the Social Security number of each dependent.

25. Complete this information for anyone (annuitant or dependent) enrolling in TRIP who has Medicare coverage. Information may be found on your Medicare card.

26. **TYPE OF DESIRED COVERAGE. Annuitants and dependents must select the same coverage.** For each person enrolling in TRIP, check the appropriate plan coverage desired based on Medicare eligibility, age, or both. If you select Managed Care, also complete for each person the primary care physician's name and six-digit number, the clinic name, and the Managed Care Plan name and code.

27. If you have other group health insurance, indicate the insurance company.

28. Be sure to complete and sign the box at the bottom of the enrollment form.

Notes

Notes

Illinois Department of Central Management Services
Bureau of Benefits
600 Stratton Building
Springfield, IL 62706

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